WELCOME!

This is to confirm _____'s
Patient's Name

appointment with: **Dana Snook, LDN, CDE, CIC**
Natalie Navarre, RD, LDN
Lisa James, MS, RD

on _____, _____ at _____.
Day Date Time

Your appointment is scheduled for our office at:

4829 Street Road, Suite 100	**31 Cambridge Lane Suite A**	**1501 N Main Street, Suite 230**
Trevose, PA 19053	**Newtown, PA 18940**	**Warrington, PA 18976**

Please do not hesitate to call us should you require directions to our office. If you prefer, you can print directions from our website: www.MKPEDS.com.

Prior to your visit, please review and complete the enclosed information and bring it with you to your appointment. Feel free to call our office at 215-968-5151, should you have any questions prior to your visit.

We look forward to meeting you!

MK*Plus*
Nutrition Counseling

Office Policy Information

Payment:
Payment is expected at the time of your appointment. Checks are to be made payable to MK*Plus.*

Cancellation Policy:
Individual appointments are scheduled for a specific time. You will be charged for missed individual appointments unless the office is notified of cancellation at least 24 hours in advance, or in cases of emergency.

Confidentiality:
All information disclosed within sessions is confidential as outlined in the HIPAA notice of Privacy Practices.

Medical Insurance:
Medical insurance companies may or may not offer coverage for medical nutrition therapy. Carefully investigate the type of coverage you have. It is your responsibility to pay for your visit and to have your insurance company reimburse you if applicable. You will be provided with a receipt that you can submit to your insurance company for reimbursement.

I have read and understand the above information.

Signature of responsible party: _____

Date: _____

OFFICE COPY

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I have read and understand the above information.

Signature of responsible party: _____

Date: _____

PATIENT COPY – Please retain for your information

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Dietitian History Questionnaire and Assessment (Pediatrics)

General Information:

Child's Name: _____ Today's Date: _____
Parents'/Care Givers' Name(s): _____
Address: _____
Phone: _____ Phone #2: _____ Email: _____
Age: _____ Date of Birth: _____ Gender: _____
Reason for Appointment: _____

_____

_____

_____

Primary Care Provider: _____

_____

Address/Phone: _____

_____

Therapist: _____

_____

Address/Phone: _____

Referred by: _____
Grade in School: _____ Name of School: _____
Parent's Marital Status: ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed
Parent's Occupation(s): _____
Siblings: Brother(s): _____ Ages: _____ Sister(s): _____ Ages: _____

Medical History:

Height: _____ Current Weight: _____
Growth History: _____

_____

Are you concerned with your child's weight? ___ Yes ___ No
Mother's Height: _____ Father's Height: _____
Are you concerned with your own weight? ___ Yes ___ No
Birth Weight: _____ Breast fed? _____ How long? _____
Bottle fed? _____ How long? _____ Formula: _____
Early feeding problems: _____
At what age were foods first introduced? _____
List complications: _____

_____

Food allergies/intolerances as an infant/toddler? ___ Yes _____ No
Please specify: _____
Symptoms: _____

Normal Pregnancy? ___ Yes ___ No List complications: _____

_____

Normal Delivery? ___ Yes ___ No List complications: _____

_____

Normal Growth/Development? ___ Yes ___ No List complications: _____

Please indicate whether your child or a family member have/had any of the following conditions:

Disease/Condition	**Child**	**Family**	**Relationship**	**Treatment**
Asthma				
Cancer				
Cardiovascular Disease				
Diabetes				
Drug Dependency				
Eating Disorder				
Food Allergies				
Food Intolerances				
Kidney Disease				
Headaches				
Heart Attack				
High Cholesterol				
Hypertension				
Intestinal Problems				
Menstrual Problems				
Mental Health Issues				
Obesity				
Osteoporosis				

Other _____

_____

List any medications your child is taking or has taken in the last year: _____

_____

Is your child currently taking any food supplements, vitamin, mineral, or herbal supplements? ___ Yes ___ No

If yes, please specify: _____

Menstrual History: (Female Patient):

Age began menstruating: _____ years of age _____ Have never menstruated

Date of last menstrual cycle: _____ Weight at that time: _____ pounds

Dieting History:

Has your child ever dieted? ___ Yes ___ No How many diets has your child been on? _____

Age of first diet: ___ years Weight at that time: ___ pounds

Why did your child go on the diet? _____

_____

Exercise History:

Does your child currently exercise/participate in sports? ___ Yes ___ No

Type, duration, frequency, and intensity of exercise activities: _____

_____

_____

What types of physical activities does your child enjoy?

_____

_____

Eating Habits:

How many days per week does your child eat:

Breakfast: _____ Lunch:_____ Dinner:_____ Snacks:_____

When does your child usually snack? _____

Does your child eat out (restaurants, take-out, fast food, etc.)? ___ Yes ___ No

How often? _____

List restaurants usually chosen: _____

_____

Does your child take lunch to school or buy lunch at school? _____

Examples of food choices: _____

Does your child eat snacks at school? ___ Yes ___ No What?

_____

Who is responsible for grocery shopping? _____

Who prepares/cooks the meals? _____

Do you read food labels? ___ Yes ___ No What do you look at on the label? _____

_____

Does your child eat standing up, walking, etc.?	_____ Yes	___ No
Does your child eat in the car, on the bus, etc.?	_____ Yes	___ No
Does your child eat in front of the TV?	_____ Yes	___ No
Does your child eat while reading, on the computer, etc.?	_____ Yes	___ No
Does your child eat with others?	_____ Yes	___ No
Does your child eat faster/slower than others?	_____ Yes	___ No
Does your child eat when stressed/bored/lonely?	_____ Yes	___ No
Does your child feel bad after eating?	_____ Yes	___ No
Does your child sneak food/hide food?	_____ Yes	___ No
Does your child wish others wouldn't comment on what he/she ate?	_____ Yes	___ No
Does your child feel like he/she eats differently than others?	_____ Yes	___ No

Describe: _____

_____

Does your child know what hunger & fullness feel like?	_____ Yes	___ No
Does your child prepare his/her own meals?	_____ Yes	___ No
Does your child avoid certain foods?	_____ Yes	___ No

Please specify: _____

_____

What are your child's favorite foods? _____

_____

What food does your child dislike? _____

_____

Please list your main concerns about your child's nutritional intake: _____

Family Weight History:

Are any members of your family overweight? ___ Yes ___ No Explain: _____

Are any members of your family underweight? ___ Yes ___ No Explain: _____

Does anyone in your family diet? ___ Yes ___ No Explain: _____

Did/Does anyone in your family have an eating disorder? ___ Yes ___ No
Explain: _____

Does your family eat meals together? ___ Yes ___ No Which meals? _____

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Instructions for Completing a Food Diary

1. Write down everything you eat or drink for two days. Remember to include all of those "tastes" or food you may eat which is not a meal.

2. Measure and record the amounts of food served in common portion sizes such as cups, teaspoons, tablespoons, or describe size. (e.g. 1 large banana – 8" long)

3. Indicate how the food was prepared: fried, steamed, baked, raw, etc.

4. Be as specific as possible. Instead of "turkey sandwich," say, "turkey sandwich made with 2 slices Wonder Light whole wheat bread, 4 slices of Sara Lee deli select turkey breast, 1 tablespoon Hellman's reduced fat mayonnaise, and two 4-inch pieces of romaine lettuce."

5. List brand names of all food products, for example, oatmeal might be "Quick Quaker Oats."

6. Be sure to measure and record all those little extras: gravies, salad dressings, taco sauce, pickles, jelly, sugar, ketchup, margarine, etc. Indicate the amounts.

7. Include recipes for any unusual items you prepared at home.

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Food Journal

Name: _____ Date: _____

Time & Place	Food Eaten	Amount

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Food Journal

Name: _____ Date: _____

Time & Place	Food Eaten	Amount

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Name: _____ Date: _____

Time & Place	Food Eaten	Amount

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Food Journal

Name: _____ Date: _____

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